Q. & A. on C.P.S.

Question: **What information should be obtained for a doctor's office records from a patient who presents a C.P.S. identification card?**

Answer: Obtain the patient's full name, address, age, relationship (indicate whether a subscribing member or family member, because they may receive different benefits), C.P.S. group and member number, and ask patient to sign and verify income status. Other necessary and pertinent data are obtained from the contract code numbers appearing on the member's C.P.S. identification card.

Question: **What steps should a C.P.S. physician follow when billing for services rendered for a procedure not specifically listed in the C.P.S. Fee Schedule?**

Answer: When billing for an unlisted procedure, a written report of explanation should accompany the billing form and be addressed to the attention of the Medical Policy Committee. If this prescribed method is followed by the C.P.S. physician's office, the billing and report of explanation submitted will be especially handled for appropriate consideration to establish a fee comparable to a fee schedule item of closest similarity.

Question: **Will C.P.S. make payments for services rendered by two physicians who are in attendance on the same case at the same time?**

Answer: Only where it is warranted by the necessity of supplementary skills in cases of unusual complications or severity. Under such circumstances a written report of explanation will eliminate the need of further correspondence relating to the case. In this manner prompt payments will be assured.

Question: **I have been requested several times to submit medical reports each month on my veteran patients. Is this reporting necessary?**

Answer: An adequate medical report is necessary each month for several reasons. A veteran is eligible for treatment at government expense only for the condition or conditions for which he has been rated as service-connected. Adequate medical reporting is essential so that the authorizing official of the Veterans Administration can be sure that government funds are being spent in a legal manner. Conditions receiving treatment for which the veteran is not service-connected should be paid for by the veteran as a private patient. Physical findings are also important in order that the severity of the veteran's present condition may be evaluated by the Veterans Administration. These findings have a definite bearing on the amount and type of treatment which can be authorized. They also have a direct bearing on whether conditions adjunct to a service-connected condition will be covered at government expense.

Question: **Are Korean veterans eligible for out-patient treatment under the Veterans Home Town Care Program?**

Answer: A new directive received by C.P.S.-VA is designed to cut red tape and grant immediate out-patient medical care to Korean War veterans. One year (or more in cases of psychosis, tuberculosis, multiple sclerosis, etc.), immediately following the veteran's discharge, is designated as a "presumptive period" during which any medical disability arising is "deemed to have been the result" of the veteran's period of active service in the Armed Forces.

Immediately upon receipt of a claim from the veteran (Form 526), authority for treatment is issued on a prima facie basis to the physician of the veteran's choice, without waiting for approval of such claim by the Adjudication Boards.

Question: **Why does C.P.S. require certain members to complete endorsements of service for pre-existing conditions, while in other cases this is not required?**

Answer: Any member who applies for *group* membership when first eligible is not required to fill out these forms. However, underwriting experience clearly demonstrates that those persons who are "self-selected risks" (a person who did not enroll in C.P.S. at the time a group was first formed) should only be accepted subject to a statement of health, and exclusions of benefits for all preexisting conditions. This policy is sound from an underwriting standpoint, and serves the best interests of all C.P.S. members. In this manner, those members enrolling in C.P.S. when first eligible, who in most cases have no knowledge of their immediate need for services, will receive maximum protection.

Question: **When a C.P.S. member leaves his place of employment and transfers to the Direct Payment Program, where the Two-Visit-Deductible coverage is no longer available, is the Medical-Care-While-Hospitalized contract considered a new contract?**

Answer: If a member had Two-Visit-Deductible coverage under his group contract, and received maximum benefits under that contract for any condition, he would still be eligible for completely new benefits for the same condition, if he should take out Medical-Care-While-Hospitalized on the Direct Payment contract.